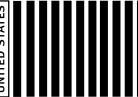
### MAIL ORDER REGISTRATION INSTRUCTIONS FOR COMPLETING THIS FORM: 1. Complete all portions of this form by printing in ALL CAPITAL LETTERS using BLACK INK. 1. PERSONAL INFORMATION 2. Fold the completed form and place it in the pre-addressed envelope provided. 3. Place your prescriptions in the envelope with the form. 4. Include your check or money order (if not paying with a credit card). Sponsor Social Security Number M.I. Last Name **Beneficiary First Name** Beneficiary Physician Last Name (If Known) Physician Phone # (If Known) Gender: Birth Date: Family Member 1 Family Member 1 First Name M.I. Last Name Physician Phone # (If Known) Physician Last Name (If Known) Birth Date: Gender: Family Member 2 Family Member 2 First Name M.I. Last Name Physician Phone # (If Known) Physician Last Name (If Known) Birth Date: Gender: Family Member 3 Family Member 3 First Name M.I. Last Name Physician Last Name (If Known) Physician Phone # (If Known) Gender: Birth Date: Instructions for Completing the Drug Allergy Conditions 1. For each Beneficiary, mark an "X" in the appropriate box. 2. If an allergy has occurred with a medication not listed below, please list it in the space provided at the bottom of this chart. FAMILY MEMBER 1 FAMILY MEMBER 2 FAMILY MEMBER 3 **BENEFICIARY** No known allergies **Drug Allergy Conditions** Codeine Penicillins (Ampicillin, Amoxicillin, Others) Cephalosporins (Keflex, Velosef, Suprax, Cefzil, Others) Sulfa Type Drugs (Celebrex®, Glyburide®, Glucotrol®, Micronase®, Others) Aspirin and non-steroidal pain relievers (Ibuprofen, Naproxen, Vioxx, Celebrex®, Others) Other health conditions, medications and

drug allergies



### CLASS MAIL PERMIT NO. XXXXX PHOENIX, AZ. MAIL REPLY USINE

FIRST 8

ADDRESSEE PT ≃ C o B∡ S EXPRESS Charting the Futu POSTAGE WILL BE PAID

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TEMPE, AZ 00000-0000 PO BOX 0000

☐ PLEASE CHECK HERE FOR CHANGE OF ADDRESS



## **Review Your Prescription**

✓ Check to see if the patient name is clearly written on

- the prescription.

   If not, print the patient's full name, address and phone number on the back of the prescription.
- Check to see if the doctor's signature is legible.

   If not, circle the doctor's preprinted name on the prescription, or print the name of the doctor on the back of the prescription. 7
- Check to see if the doctor's phone number is printed on the prescription.
   If not, print the doctor's phone number, including area code, on the back of the prescription.

# Make sure you have completed the Allergies

Review Your Order Form

section. This enables our pharmacists to review your patient record before filling your prescription.

## HEARING IMPAIRED: XXX.XXX.XXXX

Toll-free, 866.D0D.TMOP (866.363.8667) FOR REFILLS: www.express-scripts.com

2. SHIPPING INFORMATION	NOTE: You must provide a U.S. postal address.  Prescriptions cannot be mailed to private foreign addresses.
First Name	Last Name
U.S. Postal Address, Including APO/FPO	
o.o. Postar Address, morading Air Office	
City	
State ZIP Code	Phone #
3. PAYMENT INFORMATION	Standard delivery of your order is free. Your order will arrive within 10 days from the date you mail your order. To expedite shipping, you may choose to have your order sent by next-day delivery, after it is processed, for an additional charge.  (NOTE: This will only affect shipping time, not the processing of your order.)
Please include payment with your order. <b>DO NOT SEND CASH</b> . To calculate your payment, refer to your <i>Beneficiary Guide</i> for your copayment.  Add \$18 if you want next-day delivery.	
Check/Money Order	Amount Enclosed: \$
Credit Card #:	Exp. Date: M M - Y Y
Credit Card #:	Exp. Date: M M - Y Y
NO	TE: All future orders will be charged to one of these credit cards.
Card-Holder Name:	Please print name as it appears on card.
	riouse print name as it appears on oura.
	X AUTHORIZED SIGNATURE
As required by the U.S. Department	of Defense, we will dispense FDA-approved generic medications when allowed by your physician.
4. SIGNATURE INFORMATION	
SIGNATURE REQUIRED →	X SIGNATURE REQUIRED
IF APPLICABLE, PLEASE SIGN THE FOLLOWING STATEMENTS ONLY	
I request that this and future orders be Required." I understand there will be a charge for this service.	e shipped "Signature I would like my prescriptions dispensed in NON-child resistant caps.
X SIGNATURE REQUIRED	X SIGNATURE REQUIRED

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